

VI

THE DIAGNOSIS AND TREATMENT OF NON-VENEREAL AFFECTIONS OF THE GENITALIA

DISCUSSION

DR. H. M. HANSHELL expressed the pleasure with which he had listened to Dr. Semon's paper, and looked forward to the profit he would gain by a closer study of it when it appeared in print. The speaker would touch only on some lesions more or less common in the tropics, but seen in this country only occasionally in seafarers and in others returned from the tropics. Such a lesion as elephantiasis of penis, scrotum, or vulva could hardly be mistaken for anything else. Another "filarial" lesion of the penis had been seen even in this country, viz., the urticarial ("Calabar swelling") œdema of infection with *Filaria loa*. The patients had been in West Africa or in Guiana, and microscopic examination of a drop of their blood would reveal the *loa* embryos. In one case seen by the speaker in 1910, urticarial swelling of the skin of the penis developed very rapidly and hugely. The bewildered patient took a headlong midnight drive down to the old School of Tropical Medicine in the Royal Albert Dock—for a doctor called to his hotel to see him had proposed instant slitting up of the prepuce. At the School the bludgeon prepuce was only photographed. There was no known effective treatment—except that sometimes as the parent worm wandered slowly across the front of the eyeball, under the conjunctiva, it could be held up there and extracted through a small incision. If it were the only *loa* in the patient the disease was ended. It was transmitted by a blood-sucking gadfly, of the genus *chrysops*. It was perhaps *à propos*, said the speaker, to mention that he had once in West Africa to treat a rather free hæmorrhage from the glans penis of a white man, caused by the deep stab of one of these "mangrove" flies.

Of course, in the tropics, various parasitic lesions might be noted first, and only, on the male genitalia.

NON-VENEREAL AFFECTIONS OF GENITALIA

In Africa small children and boys were very often naked. The men, "uncivilised," often no more than screened the genitalia from view, and in some tribes not even that at all. All squatted, and so often squatted with long prepuce-tip in the dust. In consequence the chigger flea did sometimes make her first entry into the preputial skin. The small itching sub-epithelial whitish lesion that marked her site was rarely seen in the African by the white doctor; for the Africans were more adept than any doctor in extracting the flea, at the point of sharp thorn or needle. The wise white doctor, in fact, got his own toes searched for chiggers, and, if present, removed by his negro servant "boy." (A newcomer sent out to the tropics on railway construction duties, once travelled by special engine and coach far down the line and called up at night the one available railway doctor to treat chiggers in his toes. The doctor told him to go to another still more tropical destination and get his own "boy" to dig them out—that was not a doctor's job. This was quite reasonable of the doctor, but too hasty. *Ex pede Herculem* . . . the chiggered traveller was a Boss; and very soon the doctor lost his job.) The chigger lesions—often there were several, or even many—might get septic. If in the prepuce, the horrid cellulitic swollen mass was best treated by circumcision.

The lesion of oriental sore (*Leishmania*), leprosy, and yaws, might appear first on the genitalia. Other curiosities observed by the speaker had been the maggot of a *Cordylobia* fly wriggling in the heart of the "boil" it had caused on a white man's penis; and the head end of a guinea worm protruding in the characteristic bulla at the end of a long negro prepuce.

Certain dyaks of North Borneo punched and clamped a fair-sized brass button through the ventrum of the urethra just behind the glans. It was a sign-penile of entry into full manhood. In one of these the button was surrounded by indurated everted ulceration, clinically epitheliomatous, but as a rule the button causes no harm, even if, to European eyes, it is not even decorative.

Among seafarers tattooing of the penis appears to have gone out of fashion. Ancient shellbacks so adorned now blushed and apologised gruffly for that old-time youthful self-expressionism. In recent years the speaker had seen two cases in young seamen. One of cellulitis,

BRITISH JOURNAL OF VENEREAL DISEASES

the other of cellulitis with localised sloughing (diagnosed as "venereal phagedœna"), both cases the result of recent amateur tattooing of penis in the fo'c'sle.

A lesion which perhaps did arise, but if so very rarely in this country, was "*climatic bubo*," or "*paradenosis inguinalis*." The speaker had seen one case, so diagnosed by him, and possibly wrongly diagnosed, in a young seaman who had journeyed only round the coasts of Britain; and in a landsman whose nearest approach to the tropics had been a coitus in Marseilles. It was, however, not very rare in the tropics, nor in men recently from the tropics, for some were invalided home on account of it. It was characterised by inguinal adenitis with marked periadenitis, on one or both sides. Suppuration might occur, but was rarely as much as in cases of bubo with, or after, chancroid. At some period there was low irregular fever which might continue for weeks. The patients denied chancre, and there was usually no scar or sign of such. Very rarely they themselves had noticed, just before the inguinal glands became enlarged and tender, small superficial pin-head ulcers on glans or in post-coronal sulcus. If the case were seen early enough these ulcers might be detected together with a subacute balanitis. The ulcers rapidly healed, but the inguinal adenitis and periadenitis, especially the latter, progressively increased. Pain was not very noticeable. All gave a history of coitus a few days to three weeks before the glands became enlarged and tender. Perhaps it was, therefore, a "venereal" disease. The label "climatic" was however too useful a one to be lightly dropped. It might not be an unreasonable one, for in the speaker's experience the lesion was noticeably commoner in the crew, officers and men of the hot, moist engine room than in deck officers and men. No organism had yet been found guilty of causing the lesion. Sections of the glands showed proliferation of large endothelial cells rather than the small round-celled infiltration of chancroid buboes. The condition might last for weeks or many months. Excision did not shorten invalidism, instead it led to secondary pyogenic infection and very slow healing. All the glands right down to the iliac vessels were usually affected; at times thorough surgery had extirpated them all, and been followed by elephantiasis of penis and leg. Nearly all cases rapidly recovered on treatment by bed,

NON-VENEREAL AFFECTIONS OF GENITALIA

sterile aspiration of any pus present, and intravenous "protein shock."

This paradenosis or climatic bubo had not yet been recorded in the woman. In the speaker's experience, and so far as his acquaintance with the literature went, it was an affliction of only the prepuce-bearing man. The circumcised escaped.

Ulcerating granuloma pudendi, a true "venereal" disease, was not very uncommon in some parts of the tropics, where it was oftener seen in women than in men. There was a small crop of cases after the Great War in soldiers who had served in Africa or in the East. It was otherwise seen occasionally in this country in seafarers, and in landsmen invalided home from the tropics on its account. The speaker had seen five cases in London in the last six years—three in white men and two in Chinese sailors. It was usually diagnosed first as syphilis, and after anti-syphilitic treatment failed, often then as carcinoma, and extensive amputations had been performed. As a rule healing was rapid with treatment by antimony intravenous injections. The ulceration was painful, deep and undermining, the granulations dark, and the discharge often malodorous. There was steady spread upwards at one end, and slow healing with much scarring at the opposite lower end. The inguinal glands were unaffected. It might run a course of eighteen months to three years, and in that time destroy all the genitalia, the perineum, anus, rectum, pubes, and even open into the bladder. Some years ago such a condition was seen by the speaker in an ex-soldier who came under the care of Dr. Manson-Bahr just a few days before merciful death from exhaustion released that many-hospitalised patient from his agonies.

The lesion appeared a few days to ten days after coitus. If the initial deep painful ragged ulcer were freely excised the disease was ended. An intracellular bacterium had been described, but at present no micro-organism had been convicted, or even reasonably suspected, of being the specific cause of the lesion.

In conclusion, the speaker pointed out that apart from the "venereal" herpes genitalis, a herpes like that occurring round the mouth in febrile conditions might occur also on the penis. He had seen two such cases during the febrile paroxysms of benign tertian malaria.

BRITISH JOURNAL OF VENEREAL DISEASES

In one the rather painful herpes lesions were confluent, with superficial greyish slough and an inflamed base distinctly indurated. It had been diagnosed as, and treated for, primary syphiloma. When seen by the speaker (on the matter of continuation of anti-syphilitic treatment) only a smooth pink scar on the prepuce remained. Next day, however, there was a recurrence of the malaria febrile paroxysm, and a lesion as above described, identical (so said the patient), with the former lesion, appeared on another part of the prepuce. Repeated search in it for *Sp. pallidum* proved fruitless. During the malaria paroxysm the patient's blood serum gave a weak Wassermann-positive reaction (as is well known may occur in malaria), but it became, and remained, completely negative during the next three years. Anti-syphilitic treatment had not been continued.

Dr. T. ANWYL DAVIES said that neither Dr. Semon nor Dr. Hanschell had mentioned what the speaker thought was a not uncommon cause of vaginitis, namely, the *Trichomonas vaginalis*, which might become pathogenic in the presence of other organisms favouring its growth. Examining cervical secretion by the dark-ground method, one sometimes found this organism in overwhelming numbers. They were not frequently spotted, because they did not show with the stains in ordinary use. Patients complained of severe persistent irritation and a greenish discharge.

He had also seen vaginitis and cervicitis due to scabies, which might be classified as a venereal disease, but he would consider trichomonas vaginitis a non-venereal disease, as the organism was a normal habitat of the intestinal tract.

Dr. DOBLE congratulated Dr. Semon on his paper. The only criticism he could make was that so many diseases had been mentioned, but the very commonest, like scabies and lichen planus, had not been underlined. The early manifestation of the latent disease, where the penis only was affected and no mouth lesions were visible, was rather difficult.

As regards Dr. Hanschell's remarks on climatic bubo, an alarming outbreak of this disease occurred amongst the Shanghai Defence Force. There it was found that excision of the glands was not a good method of treatment.

NON-VENEREAL AFFECTIONS OF GENITALIA

Referring to ulceration of the genitalia, two cases at the Military Hospital, Rochester Row, were cured by an autogenous diphtheroid vaccine after all other methods of treatment had failed and the ulceration had spread over part of the thigh and abdomen.

Dr. BUCKLEY SHARP said that he thought that Dr. Semon should retain the original title of his paper, because he, the speaker, considered that the division of diseases that could be transmitted by sexual union was merely arbitrary, syphilis, gonorrhœa, and soft sore being termed venereal, whereas herpes genitalis and warts were not, though similarly transmitted. He was certain that herpes genitalis arose in other ways in addition to direct transmission, as it was seen in such diverse conditions as pregnancy toxæmia and acute gonorrhœa. He asked Dr. Hanschell whether in climatic bubo the glands suppurated, and what were the treatment of the condition and the differential diagnosis from bubo due to soft sore.

He did not consider that diphtheroid infections of the genitalia, other than by Klebs-Loeffler bacilli, were pathogenic, or that they responded to vaccine treatment or local treatment, and described the condition in female children before the age of puberty.

R. MORTON said he could elaborate the last speaker's remark about diphtheroid infections. He remembered a girl in an institution who had a rather purulent conjunctivitis, from which a diphtheroid bacillus was cultivated. She also had a vaginal discharge, and the reason it was specially investigated was that at that time there was in the institution an epidemic of diphtheria. Various treatments, including a vaccine, were tried, but without avail.

With regard to adenitis due to trichinoma, in a routine examination of fæces it could be found in large numbers, especially in liquid stools. It could be found in the vaginal discharge without employing dark-ground illumination, by taking a little of the discharge and emulsifying it with normal saline, and examining it with a 6 lens. The speaker did not think it was pathogenic; it was found in the mouth, and commonly in the stools, and he did not know why it should be pathogenic in the vagina.

Dr. MARGARET RORKE said those engaged in gynæcological and venereal disease work felt that pruritus ani and a similar irritative condition of the vulva was a most

tiresome condition to treat. She agreed that nearly always, in these cases, there was a small focus which had been missed at the beginning. Later the whole skin of the region became altered in its constitution, so that ultimate cure was difficult. In one or two such cases the only agency which cleared up the condition was X-rays.

Warts in women were often associated with an irritating discharge; and after trying to get rid of them, by the cautery, or chemicals, it was found that the best method was surgery, clipping each one off with fine scissors, clearing off any bleeding there might be, and dressing for twenty-four hours with 5 per cent. phenol and glycerine. After that no dressing was needed. Only very rarely was there recurrence. A certain type of person seemed very prone to have these warts or polypi.

In her experience, trichinoma had only been found in the vagina in cases of purulent gonorrhoea or in association with *B. coli* infection. They were demonstrable diluted with saline under the ordinary microscope.

Dr. DOROTHY LOGAN said she had a young woman who was in her seventh day of lying-in, and had been under mercurial treatment because of a positive Wassermann. She had had no lesions during pregnancy, and there was no definite history of the disease. The speaker did not feel justified in giving her N.A.B. or more active treatment than mercury. She developed punched-out ulcers, such as might have been expected from a pencil-end dipped in caustic, on the labia minora and the orifice of the vagina. But there was no such external reaction as might follow caustic. A culture taken proved to be diphtheroids, and it was said to be Klebs-Loeffler bacillus. She was transferred to a fever hospital, but the speaker did not succeed in getting a report as to whether the organisms were diphtheroids.

Three years ago a lad aged twenty-five, with swelling of the penis and constriction of the prepuce, was seen by the speaker, and the house surgeon proceeded to relieve the constriction. Within a fortnight there appeared a large cauliflower growth, an epithelioma, for which it was necessary to amputate the penis.

She had had one case of pruritus which she took to be venereal; it was a most intractable pruritus vulvæ in a woman who also had the anal condition for eighteen months. She had been to eighteen doctors before she

NON-VENEREAL AFFECTIONS OF GENITALIA

arrived at the venereologist at King's College Hospital, and he sent her to the speaker as an anal gonorrhœa case. She had marked erosion of the cervix, and an irritating discharge from that. Gonococci were not found, but she did not doubt the diagnosis.

Dr. T. ANWYL DAVIES, in further remark, said he well remembered a case of vaginal discharge referred to him by Dr. Logan in which he was forced to make a diagnosis of trichomona vaginitis. The patient had some curious yellow patches on the vaginal wall and a profuse frothy discharge. His attention was attracted by the great number of trichomona organisms in the discharge, and the absence of gonorrhœa. The patches cleared up rapidly on mild alkaline douches, and he could only assume that they were due to this organism which was said to be normally present in 30 per cent. of vaginas. It was, of course, a migrant from its normal home, the Lieberkuhns glands of the intestine, and he thought in some cases, like *B. coli*, it could become mildly pathogenic.

It could be readily detected by the hanging drop, but this method was unusual in the routine of a venereal clinic, and by ordinary staining it was not seen.

The PRESIDENT expressed, on the Society's behalf, cordial thanks to Dr. Semon for his paper. All who were occupied in clinical work associated with venereal disease must feel what a privilege it was to have such a paper, reminding them of conditions, other than the usual ones, which it was well to look out for.

He could understand Dr. Semon's desire for preferring the modified title; he did not wish to occupy time in talking about soft sore when he had so much else to communicate.

The only definition of venereal disease the speaker knew was that used in the official regulations, and if that was accepted, the title "non-venereal" would be correct for the paper. In those regulations venereal disease was defined as syphilis, gonorrhœa and soft chancre, and so everything beyond that was non-venereal from the point of view of the official regulations.

He felt, as one of the speakers indicated, that to-night members were having a magic-lantern show, going too rapidly over various subjects, and Dr. Semon would have been gladly heard at greater length on some of the diseases.

BRITISH JOURNAL OF VENEREAL DISEASES

He, Dr. Coutts, was interested in the opener's remarks on X-ray treatment, as it seemed extraordinarily valuable in some of the complaints, yet it was a remedy which must be applied with great caution. These X-rays had been used for lupus, and the result was sometimes the production of epithelioma. Did such a disaster occur in any of Dr. Semon's cases, or was the worst result some X-ray dermatitis?

Dr. SEMON, in reply, thanked those present very sincerely for the kind way in which they had received his paper; he asked pardon for the sketchy way in which he had presented the subject, but it was such a vast one that it could well occupy half a dozen lectures.

The President's kind suggestion that the title was a legitimate one as it accorded with the official designation of venereal disease, obviated the necessity of the speaker explaining why he chose it.

Dr. Hanschell had called in question the subject of herpes genitalis. The form he, Dr. Semon, was referring to was the recurrent type; it was not that met with in febrile disturbances, such as herpes labialis. There was a type of herpes genitalis which continued for years, and might occur after the menstrual period, or after coitus with one particular person. That infection might be latent, and show itself from time to time. Its virus was unknown. He thought Callomon's view, that it was allied to the virus of the common wart and *Molluscum contagiosum*, might be accepted *pro tem*.

Vaginitis due to scabies was new to him, though the infection was common on the penis.

Dr. Doble rather took the speaker to task for not having emphasised lichen planus sufficiently, but he did enter into it somewhat fully. It was frequently mistaken for tertiary syphilide of the non-ulcerative type.

With regard to diphtheroid ulcerations, in dermatology nowadays, a diphtheroid diagnosis was not accepted; it was regarded as a secondary involvement on some primary condition. The great point about diphtheroids was to exclude k.l.b. infections.

Leucoplakia of the vulva was not a very common disease, and in his experience it was incurable. The cause was unknown. The symptom was usually pruritus. He had one very severe case which rapidly, while under observation, proceeded to epithelioma. X-rays were

NON-VENEREAL AFFECTIONS OF GENITALIA

tried, but recurrence took place. The steam cautery of Mr. Souttar resulted in a temporary cure ; the glands had been excised previously. He would expect the disease to end fatally in time. Malignant infections sometimes lay dormant, then took on renewed activity, even after extensive surgery had been carried out.

Leucoplakia might occur on the penis, and here, he thought, the condition must be different. It required no particular treatment, but must be differentiated from syphilis.

With regard to X-rays, he thought the reason they were so much used for affections in the genital area was because of the delicacy of the membranes, which prevented the use of the usual local applications, such as tar, chrysarobin, etc., which were useful on other parts of the cutaneous covering. If the dosage of rays was right, no damage was done to the delicate mucous membrane, but efficient screening of rays must be ensured. The effect of X-rays on the cutaneous nerve endings was to paralyse them for the time being. In pruritus vulvi and ani, the effect of the rays was so rapid that the patient would sleep comfortably within two or three nights of the dose of rays being given. This could not have been due to any changes in the structure of the part irradiated, it must be due to a temporary paralysis of the cutaneous sensory nerves. X-rays should never be used at all for lupus, and he did not think any dermatologist of standing did so at the present day. One was seeing now the results of rays administered five or ten years ago for lupus ; the lupus was removed, but secondarily there had occurred intractable ulcers and epitheliomata.